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CONTRACTUAL PRINCIPLE VERSUS LEGISLATIVE FIXES: COMING TO CLOSURE ON THE UNENDING TRAVAILS OF MEDICAL MALPRACTICE

*Richard A. Epstein**

INTRODUCTION

The subject of medical malpractice liability burst into prominence in the mid-1970s, and with ebbs and flows has continued to attract anxious attention over the past thirty or so years. To give some idea of the current temperature on this question, it is only necessary to look at last year's budget controversy in the State of Illinois. The state budget is now being held hostage by the issue of medical malpractice reform, where Illinois Republican state legislators are backing physician proposals that would protect physicians' homes and other personal property from satisfying plaintiff judgments in medical malpractice cases.¹ Thus, it has been reported (anecdotally, of course) that physicians have retired early, restricted their practices, left the state, or gone without insurance because they cannot cope with the high malpractice rates that have been, they claim, fueled by the high medical malpractice verdicts within the state.² The plaintiffs' bar is dead set against the proposal, which it argues operates as a de facto cap against damages, as physicians who know that their personal assets are insulated from suit will be more willing to roll the dice at trial because they have much less to lose from an adverse judgment.³ In

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1. Christi Parsons, *Illinois Doctors Press for a Malpractice Limit*, CHI. TRIB., July 9, 2004, § 3, at 1.

2. *Id.*

3. *Id.* The basic calculation is this: the upper bound constrains the loss, which makes the gamble more attractive, just as it does in any case where an insurer in charge of the defense has included occurrence limits in the basic policy. For example, suppose there is a case that has a fifty percent chance of a \$1 million verdict and a fifty percent chance of a \$0 verdict. The expected value of that case is \$500,000. The insurer who has written a \$500,000 policy will not be willing to settle for that amount because rolling the dice gives him an expected loss of \$250,000, given that he will only have to pay the \$500,000 the fifty percent of the time he loses. Even if administrative and litigation costs are \$100,000, he is still better off litigating. The insured of

their view, the special status that physicians claim for themselves is just another form of privilege that should be resisted in the name of full redress of injuries in the courts.

A very different view of the matter has been taken by Brad Cole, the mayor of Carbondale, Illinois.⁴ Cole noted that the only two neurosurgeons in southern Illinois, both headquartered in Carbondale, had packed up their practices and relocated to another state in order to reduce their malpractice premiums. According to Cole, "the real problem—for many communities similar to Carbondale—is the declining availability of physician care in rural and mini-urban areas."⁵ In his mind, the dithering on medical malpractice reform in Springfield, Illinois required prompt action.⁶ Hence, under its home-rule authority, Carbondale enacted an unspecified cap on non-economic damages in medical malpractice cases, and topped it off with a venue provision that stated that all medical malpractice cases arising within Jackson County (where Carbondale is located) must be tried in the local jurisdiction to make sure that the cap remains firm.⁷ The unilateral action is a measure of quiet desperation because the Illinois Supreme Court has already struck down a damages cap on a variety of constitutional grounds.⁸ But, at least within the current legal framework, there is some elemental economic logic behind the provision. Of the many different medical malpractice reforms, the only plan that seems to have some traction is a cap on non-economic damages, which, as used in California, reduced overall verdicts by about thirty percent according to a detailed Rand study, with a still steeper drop in attorneys' fees.⁹

course is unambiguously worse off, since it faces a \$250,000 exposure (one-half of the \$500,000 excess) and gets no benefit from the favorable verdict. The duty of good faith requires the insurer to treat the insured's loss as if it were his own. Where there are hard limits on assets, there is no party who loses when the dice are rolled, because there is no insurer in the picture at all. See, e.g., *Merritt v. Reserve Ins. Co.*, 110 Cal. Rptr. 511 (Ct. App. 1973).

4. Brad Cole, *When Doctors Start Leaving Town*, CHI. TRIB., July 13, 2004, §1, at 19.

5. *Id.*

6. *Id.*

7. *Id.*

8. See *Wright v. Cent. Du Page Hosp. Ass'n*, 347 N.E.2d 736 (Ill. 1976).

9. See RAND Inst. for Civil Justice, *Changing the Medical Malpractice Dispute Process: What Have We Learned from California's MICRA?*, at <http://www.rand.org/publications/RB/RB9071> (last visited Sept. 9, 2004). MICRA is an acronym for California's Medical Injury Compensation Reform Act. The key finding of the study reads as follows: "The cap on non-economic awards was imposed in 45 percent of the cases won by plaintiffs in the sample. Defendants' overall liabilities were reduced by 30 percent as a result of MICRA." *Id.* The study also indicated that the most likely cases to be capped were death cases, cases of serious injury, and cases of injuries to persons under one year of age. *Id.* On average, the defendants' liabilities were reduced by thirty percent and the attorneys' fees (because of the sliding scale) were reduced by sixty per-

The ugly nature of this protracted controversy, which has now spilled over into the political arena in Illinois, and doubtless elsewhere, should give pause to everyone on both sides of the medical malpractice debate. I do not want to use this occasion to give a clean bill of health to caps, although on balance, I would support them as a decidedly second-best measure in light of the current impasse. But it is, I think, more important to think things through from a first-best perspective. I start from the simple premise that on balance the gains from the provision of medical services are strongly positive, so that it should be possible to fashion a legal regime from which both patients and physicians gain. But the magnitude of the current impasse, as well as the contraction and withdrawal of vital services in the face of those positive benefits, is a sign of deep disorder within the health care system, a point which neither side in the debate has grasped. Before I analyze the four articles that address important aspects of this recurrent problem,¹⁰ it is useful to explain why current disputes will continue without abatement until there is a fundamental rethinking about how to design medical malpractice liability regimes. More specifically, in the current debate both sides think that either the legislature, the courts, or both should design the rules of liability for these cases. Thus, after the question of *who* should decide in favor of some public law situation, the next question of *how* the decision should be designed becomes roiled in hopeless political conflict. Contrary to the received wisdom, there is no way to get the right result so long as we keep asking the *how* question without looking first at the *who* question.¹¹ In my view, the answer to that initial choice of *who* is that the parties and not the state should decide the terms of liability.

Stated doctrinally, the key error is to treat this as a *tort* problem when designing a governance regime calls for a contractual response. The rigidity arises because the unquestioned (and badly defended) view of modern American courts is that the source of the duty of care in medical cases is the law of tort, and that its commands cannot be

cent. *Id.* Plaintiffs' net recoveries were reduced by fifteen percent, again because the larger share of the burden was absorbed by the lawyers. *Id.*

10. Jeffrey O'Connell & Evan Stephenson, *Why Binding Offers by Defendants, Not Plaintiffs, in Personal Injury Suits?*, 54 DEPAUL L. REV. 233 (2005); Michael J. Saks et al., *A Multiattribute Utility Analysis of Legal System Responses to Medical Injuries*, 54 DEPAUL L. REV. 277 (2005); Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247 (2005); Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205 (2005).

11. For more complete statements of the position, see Richard A. Epstein, *Medical Malpractice, Imperfect Information and the Contractual Foundation for Medical Services*, LAW & CONTEMP. PROBS., Spring 1986, at 201; Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87.

varied by any agreement between the parties over such matters as the proper standard of care, the proof of causation, or the measure of damages.¹² The system therefore has ossified into one of judicial regulation that is impervious to corrections from private parties with better information as to the operation and effects of the system on such critical matters as access to, and levels of, care. An approach of strong judicial control makes sense in that important class of cases where the plaintiff and the defendant are *strangers*, not linked together by some common enterprise, at which point it is both possible and desirable to use the tort law to keep people apart so that in a regime with clear property rights they can resort to voluntary means to bring themselves together.

In cases where the plaintiff and defendant are strangers, it makes sense to use a system of strict liability, or that failing, a system of negligence law that adopts a high objective standard of care that does not cater to the whims and weaknesses of individual parties. The objective of the system is to deter the harms that one person causes to another so a rule that forces one party to compensate the other fully will in general produce the optimal deterrence against various forms of dangerous conduct.¹³ The issues that remain include finding out what harms are linked to what conduct, which raises additional issues of factual connection and proximate causation, the question of whether the plaintiff's own conduct has been the source of his or her injury, and, of course, the measure of damages. No one can claim that the traditional tort law has been a model of perfection in dealing with these issues, for it is always possible to find decisions and distinctions that are worthy of regret, such as the awkward line between damages caused by concussion and those caused by tangible matter in blasting cases, which was eventually put to rest.¹⁴ But by the same token, the relative political calm that surrounds these tort rules in stranger cases carries with it a strong message that matters are not far amiss in this portion of the tort world.

12. See *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441 (Cal. 1993). For criticism, see Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 172. See also PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 95-105 (1991) (discussing the possibilities of wholesale and retail substitution of contract for tort in the malpractice setting).

13. See, e.g., WEILER, *supra* note 12, at 70-73; Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29 (1972) (discussing the Judge Learned Hand formula found in *United States v. Carroll Towing Co.*, 159 F.2d 169 (2nd Cir. 1947)).

14. See, e.g., *Spano v. Perini Corp.*, 250 N.E.2d 31 (N.Y. 1969), *overruling* *Booth v. Rome, W. & O.T.R. Co.*, 35 N.E. 592 (N.Y. 1893).

The situation is quite different in connection with physical injuries that arise out of consensual arrangements. Here, medical malpractice and product liability (except in the occasional bystander claim) cases have been the source of intense controversy and acrimony over the past thirty years.¹⁵ The root intellectual cause of this difficulty is the widespread judicial determination to carry over many of the same rules that apply in stranger cases to the different context of consensual arrangements.¹⁶ But the objectives of the parties in the two contexts are too different to allow for this simple amalgamation of cases. The object of a consumer or patient is not to keep a supplier or physician at bay. Rather, it is to maximize the joint gains from trade through the delivery and receipt of goods and services. One critical portion of that endeavor focuses on the terms that govern the allocation of loss from the product or service in question. Rational consumers know that the initial transaction is voluntary, and will only take place if there is a win/win situation between the parties. From that they can easily deduce that any price for good or fee for service will have to include a financial component sufficient to cover any future liabilities stemming from the transaction. That decision is based on brute economic considerations of whether someone can afford to pay the price needed to fund the future liabilities, and that truth of the marketplace is not altered because we denominate the basic cause of action as one of tort (because of the physical injury) instead of as one in contract (because of the consensual arrangement).

Against this backdrop, the use of liability insurance to guard against loss becomes a second-order consideration. If the future liabilities are known to be large, then any insurance coverage will be expensive as well. Thus, the choice to insure will depend largely on such matters as whether insurance companies have any comparative advantage in defending against lawsuits or in allowing the firm to even out its cash flow and expenses over time. But there is no magical way in which insurance will ever be priced below the expected cost to the insurance carrier, which includes, at a minimum the costs of liability and defense, the cost of contracting with the insured, and the overall administrative load of running this system.

15. For a summary of the medical malpractice controversy's history, see FRANK A. SLOAN ET AL., *INSURING MEDICAL MALPRACTICE* 4-7 (1991). For my views on this subject generally, see RICHARD A. EPSTEIN, *MODERN PRODUCT LIABILITY LAW* (1980). See also generally George Priest, *The Invention of Enterprise Liability: A Critical History of the Intellectual Foundations of Modern Tort Law*, 14 J. LEGAL STUD. 461 (1985).

16. See generally Thomas C. Grey, *Accidental Torts*, 54 VAND. L. REV. 1225 (2001) (describing the transition of tort law from isolated applications of negligence to a freestanding body of law concerned with accidents generally).

Knowing these basic truths, rational consumers in a voluntary market (which is a far cry from the current situation) have only two choices. They can opt for high coverage in the event of loss, but only if the consumers are prepared to pay an implicit premium to match. Or rational consumers can opt for less extensive coverage, and receive in exchange a lower price, which reflects the lower insurance costs. My theory is that most consumers, if left to their own devices, would choose some package that has lower coverage and lower premiums. In part, they would make this decision because they are cash-constrained. They do not have the thousands of dollars in loose change to cover a large future damage award. In part, they make the decision because they do not wish to fund the huge donnybrooks that result from high stakes litigation—which profit lawyers but no one else. They do it in part because they think that the reputational risks from adverse judgments improve the odds that they receive good care or safe products, as the case may be. Indeed, in ordinary markets, reputation and legal protection are substitutes for each other. In most cases, some mix of the two is appropriate, but it is easy to recognize niches in which a corner solution of no liability might be appropriate: dangerous operations by prominent physicians with high risks of failure whether surgery is undertaken or not. With high-risk therapies and drugs, people will assume virtually all the residual risk because they do not think it worthwhile to buy liability coverage with respect to losses that are likely to occur whether or not the treatment is received. First party insurance—life, health or disability—is the better way to handle changes in personal wealth or fortune.

At this point, we can identify the systematic source of the liability crisis. The optimal *ex ante* contract will in most cases call for a form of liability (including expected damage payments) that is more limited than consumers receive from the current law. The present legal system fixes liability at a socially high level, and then allows the parties relative degrees of freedom on other terms. At this point, the contracts will optimize subject to the social constraint. In some cases, the system readjusts by raising prices or fees. In other cases, it shuts down entirely, with unhappiness on both sides. But no matter which way the outcome shifts, the discontent on all sides will be manifest because the current system deviates from the optimal set of contractual terms in a way that leaves both sides worse off *ex ante*. In this vein, the common complaint about the lawsuit lottery makes sense. The rational consumer is generally risk-averse and would not pay to face outcomes that could vary from nothing at all to enormous sums. Constant income over all states of the world—that is, whether the future

brings good or bad luck—is usually a closer approximation to the truth, and the standard object of most insurance contracts.

In light of this analysis, it seems clear that the most forthright and sensible way to deal with the liability crisis is to remove the minimum constraints on liability set by law and allow the parties to cut their own deals, either directly or through professional intermediaries, such as employer health care groups and the like. It takes a certain degree of guesswork to indicate what those deals might look like in any particular setting because the hostile attitude towards contracting since medical malpractice became a large issue in the 1970s has prevented any experimentation with specific terms for particular contexts. My own guess is that few providers would insist that their patients go without any legal protection at all, save that provided by the criminal law, although it is possible, as noted above, to think of situations where that might well be the best arrangement, as in high risk settings where previous medical and surgical work has complicated the task of treatment. Here, the reputation and skill of a particular physician and institution might be sufficient to provide the needed sanctions to guard against substandard medical care. But clearly in the routine cases, the quest is to find some level of sanctions large enough to make a difference in how care is provided, but small enough to be sure that the physicians and institutions are not driven from the practice of medicine, or given strong incentives to restrict their clientele to those select portions of the market that carry the lowest level of risk. I suspect that these arrangements would involve a change in the standard of care, so that the standard would emphasize good faith and customary practice; would restrict the use of *res ipsa loquitur*; would call for expedited arbitration procedures; and might place some caps on damages, perhaps for pain and suffering, but perhaps for all damages. Many of these proposals are the common gist of legislative reform, either alone or in combination.¹⁷ To the extent that they imitate private contracts, they come with a certain level of attractiveness. But by the same token, since they are not secured through market practices, they cannot be regarded as necessarily wise.

Thinking through various proposed reforms presents its fair share of pitfalls because we are always operating within the confines of a second-best universe. That said, it is critical to keep this issue in perspective: to be sure, liability issues are a tough nut to crack, but they do not loom so large as to threaten the viability of the health care delivery system altogether. Medicare, Medicaid, universal health

17. See WEILER, *supra* note 12, at 26–32.

care, licensure, emergency room care, and a host of other business issues arguably contribute far more to the cost of medical care than does the medical malpractice system. We have major imbalances throughout the system which insulate individuals from the cost of the care they receive, so that on balance the marginal gains from additional units of care are dwarfed by their associated costs: people are generally willing to spend a lot more of other people's money on their health care than they are of their own money. That problem is not unique to medical care. It is simply another illustration of how subsidized arrangements bring about an unwanted deviation between private and social costs.

By the same token, however, it is a mistake to assume that the costs of the malpractice system are limited to the direct costs of litigation, plus settlements and judgments. The incentive effects of liability rules surely matter, and these include the full range of adaptive steps that people take to avoid adverse consequences of the liability regime. The entire process of review and selection of protocol, including those activities called "defensive medicine," are part of the picture. These are likely to be large, even if difficult to estimate numerically. The decision of physicians to relocate, to restrict patients, to eliminate certain lines of work or treatment options, also count as costs of the medical malpractice system, precisely because no voluntary actions can bring the basic problem back into a sound equilibrium. If the malpractice premiums and litigation costs (which do not reflect all the direct costs of running the liability system) are about one percent of total system costs, then perhaps a figure of five percent deadweight loss would not qualify as outlandish, even if it cannot be defended in any rigorous way.¹⁸ This multiplier might get us to a \$100 billion net cost figure, which would have to be reduced to take into account any residual benefits that the extended system of liability provides.

These numbers are still large enough to attract attention, and make it reasonable to assume that some concerted market response could improve matters. For a wide variety of reasons, this first-best scenario is not likely to take place. There are of course many people who believe that consumer ignorance and desperation (or emergency situations, non-paying patients, children, and those patients lacking mental capacity) rule out the voluntary market for health care.¹⁹ In addition,

18. See Weiler, *supra* note 19, at 208 (noting that the current figures are that malpractice and insurance costs today amount to about fifteen billion dollars in a system that accounts for close to fifteen percent of the Gross Domestic Product (GDP), or \$1.4 trillion).

19. See generally, e.g., P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, *LAW & CONTEMP. PROBS.*, Spring 1986, at 287.

any such system will feature a steady but small stream of cases of truly egregious injuries for which there will be only partial compensation. It is grist for the lawyer's legal mill to insist that no system of liability is just unless it promises full and complete compensation for all injuries sustained (the stranger model), so that *ex post* rectification rather than *ex ante* optimization of expected value becomes the order of the day. Since both *ex ante* and *ex post* perfection cannot be achieved simultaneously by contract, it follows that any efficient legal system will also generate powerful counterexamples of individuals who are hurt by the restrictions on recovery. Yet what gets lost in the shuffle is the large silent cadre of individuals who would arguably get better access and better treatment once the threat of liability no longer overhangs the primary market in medical services.

If this analysis is correct, then we know the spirit in which we should approach the articles in this Symposium. Any effort to tinker with the dominant rules on liability or procedure will be a second-best affair if it does not, as it cannot, replicate the full range of outcomes generated by a consensual system of contract. Perhaps these legislative changes will not generate some small social improvement, but the absence of consensual legitimation necessarily compromises the prospects for success. It is therefore important to look upon any proposed reforms with a skeptical, but not a hostile eye. The two intertwined questions are whether the new proposal offers some modest palliation from the current turmoil and unease, and if it does, whether it has any chance of passage or adoption. My guess is that on balance the status quo will triumph over these innovations no matter what their content. The medical malpractice system is locked into an unhappy equilibrium from which it will not budge except by extraordinary political consensus, which is simply not present. Whether this status quo bias is a good thing depends heavily on the reforms being proposed. Let me now turn to these four articles.

II. WEILER

Professor Paul Weiler's article works from the premise that the central task of the law is to rationalize the system of medical malpractice, not to dismantle it.²⁰ Weiler is correct to note that it is possible to make out a credible case for the *underdeterrence* of medical mishaps in the current tort system. He can point out that many cases of probable malpractice do not make it into the system because of a patient's reluctance to sue, or by a simple misevaluation of the claim by the

20. See Weiler, *supra* note 10. By his account, Weiler seeks "rational as well as ethical" reform. *Id.* at 216.

lawyers who would take it. The numbers that he offers are quite striking. By his account, there are 115,000 negligent medical injuries or deaths, which generate only about 55,000 suits, with 15,000 cases generating some positive payment through either settlement or jury award.²¹ Even if we assumed that lawsuits are more likely in serious claims, the first cut is that the level of malpractice activity is about a fourth of what it should be, which in turn means that medical malpractice premiums are too low for the total risks at hand.

In one sense, the situation is both more complex and worse than Weiler describes it. No one should read his numbers as though they suggest that the 55,000 suits that were brought came from the 115,000 cases of negligent medical injuries, or that the 15,000 compensated cases were drawn from that same pool. It is quite possible that the system is so overheated that the awards in question are given for serious injuries which occur without negligence, while cases of serious injury with negligence remain outside the system. At this point it is no longer possible to argue that the system produces underdeterrence. Rather, the dominant feature is the unreliability of the entire system as a check on medical misconduct. After all, why should any one take care in medical practice if the likelihood of losing a case depends on the seriousness of the patient's condition and not on the quality of care provided? Under these circumstances, the right approach would be to further limit the medical malpractice system because it functions so poorly, and to substitute in its place a system of direct staff review which has the advantage in that it can look at physician performance over a run of cases and not just on the outcome of a single event. If this is the practice, then cutting back further on liability makes sense because of the weak correlation between compensation and deterrence.

The question could then be asked whether it would be rational for patients to accept a contractual restriction on their behavior, a proposal that Weiler has strongly resisted.²² A set of simple calculations suggest that he could be wrong on this point as well. It may well be rational for patients to assume the risk of *negligent* treatment. To see why this is the case, assume that if we have 100 cases, treatment will produce a net benefit of \$100,000 in ninety-nine percent of the cases, either through the extension of life or the alleviation of pain, for a total benefit of \$9.9 million. Assume further that the one percent of cases resulting in mishap are all attributable to negligence and pro-

21. *Id.* at 214–15.

22. See generally WEILER, *supra* note 12.

duce an expected loss of \$1,000,000. Under these circumstances, the expected value of a physician interaction is:

$$(.99 \times \$100,000) - (0.01 \times \$1,000,000) = \$89,000$$

In these figures, the first parenthetical represents the expected value of successful treatment in a random individual case. The second represents the expected loss from unsuccessful treatment. Their difference is the expected value because there are no administrative losses to subtract from the anticipated gain. One key point here is that the gains are likely to be substantial no matter how one values the cost of an adverse medical outcome, either from nature or from medical malpractice. If these outcomes receive higher values, then the gains from successful treatment (which avert these losses) are greater as well. Hence, the following irony: If we multiplied the expected losses from bad treatment by ten, then it follows that the gains from successful treatment should be subject to the same multiplier, in which case the net gain from taking treatment without legal protection *increases*. But no matter how the gains and losses are estimated, the constant feature of this model is that the incidence of medical malpractice is kept low because of the reputational or direct administrative controls that hospitals and practice groups impose on their member physicians.

The most obvious lesson from these figures is that people may be better off assuming the risk of *negligent* treatment than staying out of the health care system altogether. Yet is this the best we can do? Suppose we now decide to impose liability for negligence. Does that improve matters when the relevant costs and benefits are taken into account? Here, start with the favorable assumption that the imposition of liability would reduce the frequency of loss to 0.5 percent, for which there would be the same loss per instance of \$1 million plus legal expenses of, say, \$200,000 for the defendant, which is a low estimate of the costs under the current system. In order for the physician to stay in business, therefore, the fees charged must be increased by \$6,000 (\$1.2 million \times 0.005) to cover these additional costs. Yet that cost push could reduce access to care by, say, ten percent (it could be greater in Carbondale). In addition, the injured party must pay his other lawyer from the proceeds of recovery, which today runs around forty percent. Thus, even if a gross recovery is perfect compensation (e.g., \$1 million for the loss), the net loss to the client equals 0.40 of that total in light of the attorneys' fees paid. If the typical physician to patient encounter before the imposition of liability for negligence had a positive value, then consumers as a class could easily be worse off because the savings that they glean from better care are more than

offset by the losses associated with reduced access to the system. Thus, on the numbers given, the expected value to the patient equals:

$$(.10 \times \$0) + (.895 \times \$100,000) - (.005 \times \$400,000) - (.90 \times \$6,000) = \$82,100$$

On these numbers, the first parenthetical represents the cases that drop out of the system, which are treated as yielding zero expected value, even though the losses could be catastrophic. The second parenthetical represents the expected gain from the transactions that do take place. Since we had ninety percent of the former cases inside the system, of which only 0.5 represent losses, the fraction of successful transactions is 0.895, with the same gain as before. The third parenthetical represents the net losses to the injured party even after recovery from bad outcomes that occur in the 0.005 fraction of cases, such as the legal fees and expenses paid to the plaintiff's lawyer. The fourth parenthetical represents the administrative load for each of the ninety percent of cases that remain inside the system. The decline in expected value is about \$6,900, which comes in part from the loss of access and in part from the administrative costs. These numbers are optimistic in the sense that they are predicated on the assumption that deterrence works. If the wrong cases are rewarded, then the situation gets even more grim. The decline in access will be higher but the accident rate will not decline: some cases of negligence will escape detection, while other cases of good treatment will be punished. The increased realism of the assumptions is not likely to reverse the somber outcome from this hypothetical case. Of course, these numbers at best only illustrate tendencies, but they teach an important lesson: one reason private contracts tend to exclude tort liability is that it is not rational for either side to want the tort system as it is now. Hence, there are (from the *ex ante* perspective) strong demands for increased access and higher administrative costs because it is perceived that the error-ridden liability system offers little by way of deterring wrongful actions. Yet there is nothing in the Weiler approach that deals with these calculations head-on to explain the sources of gain to the parties that makes it sensible for them to retain some form of the malpractice system.

Weiler is thus committed to exposing the "true flaws" of the system as he sees them. Because he does not stress *ex ante* gains from trades, he looks at the perceived inequities of the system. He has much to say against caps on pain and suffering because they are set too low to offer full compensation for losses *ex post* and in any event become through inflation more onerous with the passage of time. I have no doubt that he is correct to denounce caps in a first-best world, at least

if they are nonwaivable affairs. Why substitute public judgment for private knowledge on a key term of the engagement? But in our second-best world, where overall damages may be too high relative to some contractual norm, it might be that caps are justified on the ground that by lowering costs *ex post*, they increase access *ex ante*, which appears to be the lesson of the California experience referred to above.²³ What is clear is that those caps which are in place will not be easily lifted because the caps' greatest vice is their greatest virtue. The hard rigidity of the number makes this constraint bite. It is probably the single most important factor in keeping overall premiums down.

All of this logic would sound foreign to Weiler because of his manifest unhappiness with contractual limitations on liability. Yet he is enough of a realist to know that the malaise requires some response, and he accordingly offers three proposals that I shall comment on briefly: (a) the use of federal guidelines for state damage awards; (b) the substitution of vicarious for individual liability; and (c) the adoption of a general system of no-fault liability for medical maloccurrences.

A. Guidelines

The type of guidelines that Weiler proposes are similar to those used in workers' compensation and sentencing cases, which have now been gutted by the Supreme Court.²⁴ The key objective of this guideline system is to eliminate the high unpredictability of damage awards. This task requires that the various sorts of injuries be broken down into particular classes and that some measure of severity be assigned to the typical injuries in each class. Once that is done on a state-by-state basis, each state will commit to an amount of money that it is prepared to funnel through the tort system, which will then become the basis for assigning dollar amounts to conditions in order of their relative severity. Juries then will be given these guidelines and entrusted with the duty of figuring out how to treat the various idiosyncratic cases that arise.

I doubt that a system like this will work. It is not clear how the guidelines will work, and there could easily be some odd pressures in states like Minnesota, where an infusion of large numbers of outsiders to the Mayo Clinic²⁵ could induce citizens to lowball the amounts of damages they are prepared to pay to others. Nor should anyone take too much comfort in any parallels to either workers' compensation or

23. See *supra* note 9 and accompanying text.

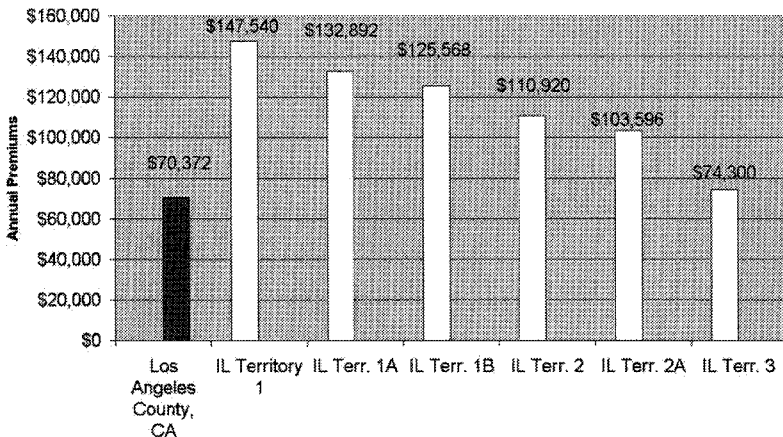
24. See *United States v. Booker*, 125 S. Ct. 738 (2005).

25. The Mayo Clinic is located in Rochester, Minnesota. See Mayo Clinic, Home Page, at <http://www.mayoclinic.com/index.cfm> (last visited Feb. 16, 2005).

the sentencing guidelines. The former system is one where it is possible to project the expected costs of the system with some predictability. The key variable is the rate of serious accidents, which can be estimated with some degree of precision, and which is known to decline in most industries with time.²⁶ But malpractice is not a first-party system. The key question for liability is not the number of injuries that occur, but the fraction of those which are attributable to negligence, and that number could vary widely by procedure and location, especially when the norms of "best practice" often vary by facility and location.²⁷ On this question, the use of state guidelines is not likely to stop the level of variation that is observed today.

The following set of data is available from a website called Reality Medicine, which offers rates in one line of the California base for Los Angeles County, California.

FIGURE 1



OB/GYN physicians in territory 1, ISMIE Mutual's largest territory, currently pay over \$147,000 annually in premiums, while OB/GYNs in Los Angeles County pay only \$70,000 for the same coverage.

Territory 1 Cook, Madison, St.Clair & Will Counties

Territory 1A Jackson, Lake & Vermilion Counties

Territory 1B DuPage, Kane & McHenry Counties

Territory 2 Champaign, Kankakee, Macon, Sangamon & Winnebago Counties

Territory 2A Bureau, Coles, DeKalb, Ogle & Randolph Counties

Territory 3 Remainder of Illinois²⁸

26. For one such study noting the decline, see NAT'L ACAD. OF SOC. INS., WORKERS' COMPENSATION: BENEFITS, COVERAGES, AND COSTS, 2001 (2003).

27. FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE 92 (1993) (stating that "physicians have a legal duty to deliver care to their patients that falls within the customary standards of the medical profession in the specialty and geographic area in which they practice").

28. Reality Medicine, Medical Liability Premiums: California's MICRA v. Illinois Obstetrics/Gynecology, at http://www.isms.org/realmedicine/info/book/graphs_em.html (last visited Feb. 17, 2005).

The two points, which the suppliers of the website duly note, are, first, a defense of caps on damages is the major source of differentiation between California and Illinois; the second is the need to impose a moratorium on new business.²⁹ But the second point is that even this aggregated data reveals close to a two-fold difference in premia that cannot be explained by variations in state law. Indeed, the process of aggregation used to compile this draft can only understate (it is not clear by how much) the level of variation, because it does not, for example, break out Cook County for its own treatment, and also ignores any variation that takes place in each county as well.

I have little doubt that a closer empirical study would lead to the conclusion that changes in state law could propel the distribution of a whole state up or down. But by the same token, the variation within states are driven not by differences in law, but by the mix of patients, cases, and juries that account for the variation. One implication of this empirical complexity is to show how difficult it would be to set numbers for the state wide caps that Weiler supports. There is no credible way in which the assignment of these numbers is likely to translate into an effective overall limitation on liability, for it is not as though once a budget allocation for the year is exhausted, everyone else has to do without. Each judge and jury could continue to go its own way, and juries that are unhappy with a low number could make findings of more severe injuries to bump cases into a higher category. There may be some certainty to the system, but the betting here is that the rigidities would provoke the same kind of resentment that exists with the sentencing guidelines, which have been subject to constant attack since their inception.³⁰ The administrative overload of this system is high, and if the guidelines really matter, the lobbying surrounding them will be fierce. This is not likely to happen, or make that much of a difference for the better if it does indeed happen.

Next on Weiler's list is the elimination of the collateral source rule, which would help the defendants, but at a price—the award of plain-

29. Reality Medicine, Reality Check: The Illinois Picture, at <http://www.isms.org/realmedicine/info/book/illinois.html> (last visited Feb. 17, 2005). Illinois's increasingly difficult medical liability climate led ISMIE Mutual to institute a moratorium on new business, effective January 1, 2003. The following market conditions forced this unprecedented decision by the ISMIE Board of Directors: escalating premium rates, rising severity, and resulting contractions in the number of insurers willing to underwrite medical liability risk in Illinois. To date, the moratorium is still in place.

Meaningful medical liability reforms include a cap of \$250,000 on non-economic damage awards. Non-economic damages, such as pain and suffering, are arbitrary and often result in inflated awards of over \$1 million.

30. For recent setbacks of sentencing guidelines, see *United States v. Booker*, 125 S. Ct. 738 (2005), and *Blakely v. Washington*, 124 S. Ct. 2531 (2004).

tiffs' legal fees in the event of recovery.³¹ Here, it is not clear whether on average the defendants gain more when collateral sources are set off against awards than they lose in having to pick up the legal fees of successful plaintiffs. Nowhere is it clear how these two numbers will vary from case to case. There is, moreover, always the real chance that the knowledge that the award to winning lawyers will follow would influence the jury verdict, although it is not at all clear in what way. It could lead to a jury reduction in the size of the award because of the awareness of the total fee. What should we think of a system that took a \$100,000 verdict and reduced it by \$25,000 to take into account collateral expenses, only to increase it by \$25,000 to reflect the contingent fee? The incentives for the defendant are about the same, even if the first party insurer loses something, and thus has to increase its premiums a bit. There are too many crosscurrents here to be confident that we know either the direction or the magnitude of the shifts, especially if juries and lawyers change their behaviors in response to the new legal rules. The uncertain patterns of cut and thrust make it difficult to know either the distributional or aggregate consequences of this reform. And that uncertainty surely makes it a nonstarter as well in the political arena, even if this reform reduces premiums, a proposition for which I do not know of any strong evidence that supports such a claim.

B. *Vicarious Liability*

I have similar doubts about Weiler's approach to the proper relationship between individual and vicarious liability. The traditional rules on the subject start with the obvious assumption that the person at fault should be responsible for his wrongs. That assignment of liability is necessarily individual, and thus faces the recurrent problem that the resources of a single person, with or without insurance, might not be sufficient to answer for the magnitude of the wrong. The system of vicarious liability is thus superimposed to make sure that some financial entity with control over the individual is responsible as well. The judgment here is that this system helps plug a gap in the compensation afforded and provides a strong incentive for those with the power of oversight to make sure that their employees do not go astray.³² In many cases, including those which involve the institutional risks of medical malpractice, the employer takes on the added burden of indemnifying the physician for any personal loss, which in-

31. Weiler, *supra* note 10, at 219.

32. See generally, e.g., Alan O. Sykes, *The Economics of Vicarious Liability*, 93 YALE L.J. 1231 (1984).

cludes the purchase of liability insurance in his individual name. It is equally common to have pooled defense programs whereby a hospital and its physician staff are covered by a single fund, often funded internally, with some excess liability umbrella policy.

Today, these internal cooperative arrangements do not bind the plaintiff, who is free to pursue all individuals—physicians, nurses, tech support, and so on—for their individual liability, as well as the employers under a theory of vicarious liability. There is little question that the plaintiffs like the current arrangement even when they know that the umbrella insurance is sufficient to cover any and all potential liabilities. There is a great procedural advantage to make a key witness a defendant, simply in terms of the ability to demand and schedule depositions. There is also the contingent benefit that individual liability might matter in the rare case in which the institutional insurance umbrella breaks down. I can see no reason why the plaintiffs would accept any system that requires them to abandon suit against the individual physician without receiving anything in exchange. Nor do I see why in most cases that change in legal regime would matter all that much. Depositions and answers to interrogatories would still be required. Appearances at court would not be eliminated. Adverse references to character with the negative effect on reputation would not be prevented. Overall, the financial savings are likely to prove negligible even if adopted. Note, ironically, that if a contractual system were put into place, the Weiler proposal could be made one aspect of the overall solution, at which point it would gain the legitimacy that it does not have when placed in the teeth of every general principle of tort liability that places individual liability first and vicarious liability second.

C. *No-Fault Liability*

The final solution that Weiler proposes is one that he has visited before: the substitution of a system of medical no-fault liability for the current negligence rules. Here, again, the obvious analogy is workers' compensation, which also has a no-fault basis. But there is one critical difference: the first workers' compensation schemes were consensual in origin, which meant that the tradeoffs on liability and damages made sense for the parties.³³ It was then possible for legislation to imitate these systems, but hardly necessary to do so. There is no parallel consensual movement here, because the causation of the injuries

33. See generally Richard A. Epstein, *The Historical Origins and Economic Structure of Workers' Compensation Law*, 16 GA. L. REV. 775 (1982).

is so different. Given that market silence, I am quite confident that medical no-fault remains a nonstarter precisely because no insurance company has the slightest interest in underwriting the coverage.

Their skepticism is easy to understand. The adoption of a no-fault system has to expand the potential scope of cases. But no one is confident by how much. We do have some experience with the Virginia no-fault insurance act³⁴ for obstetrical industries, but it has proved to be nightmarish to administer and fund. Nor can these difficulties be easily eliminated by better drafting. Here is one problem: there are many procedures that have to cause harm in order to be successful. That point is true of every scar in surgery, and every side effect from chemotherapy, none of which are compensable today. But if they are kept out of the no-fault system, then someone has to determine what events are sufficiently outside the scope of normal as to be compensable. That is likely to prove difficult for serious surgeries that have major side effects; and it creates all sorts of difficulties for new treatments whose negative consequences and risks are not fully appreciated by anyone at the outset. Nor is it possible to understand how a no-fault system could apply to missed diagnoses. If there is no negligence, then there could be no-fault liability for every undiagnosed condition. Surely that is not intended, but once again, it is not easy to think of the bandage that will cover this open wound.

These proposals have been around for thirty years, and their difficulties have been known for at least that long.³⁵ I can recall years ago attending a meeting with some insurance executives who just folded up their notebooks in disbelief once the scheme was presented. I wouldn't risk my money on this type of scheme.

III. O'CONNELL & STEPHENSON

Professor Jeffrey O'Connell and his co-author Evan Stephenson start from the assumption that we will treat the substantive rules of the medical malpractice system as a given, then alter the procedures in ways that give the defendant the advantage of binding early offers.³⁶ The defendant may offer the plaintiff this carrot: "take this offer and

34. Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. §§ 38.2-5000-5001 (Michie 2002). See, e.g., Bill McKelway, *Program at a Crossroads*, RICHMOND TIMES-DISPATCH, Aug. 13, 2002, at A1; Bill McKelway, *Unequal Treatment*, RICHMOND TIMES-DISPATCH, Aug. 11, 2002, at A1. One difficulty here is that the public finds it difficult to see why one infant whose condition is caused by innocent physician conduct gets large compensation while a second infant with the same condition caused by natural forces gets none.

35. See generally, e.g., Robert E. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1973).

36. See O'Connell & Stephenson, *supra* note 10.

receive your out of pocket expenses for medical care and lost earnings as these accrue.” The stick in this proposed regime is that if the offer is rejected, then the plaintiff will prevail only by proving beyond a reasonable doubt that the defendant had engaged in grossly negligent misconduct.

The only loose ends in this system are the same as in the current law. Someone has to figure out how to calculate the various expenses as they accrue. On the medical expense side of the picture, the inquiry will be clouded by the difficulty of deciding which portion of costs were brought on by the underlying condition or some collateral disease and which by the malpractice itself. These attribution problems will not be solved by waiting for the expenses to reveal themselves. The most that can be said is that the estimation that takes place over time may be more accurate than the once-and-for-all judgments that are made whenever lump sums are awarded under the current system. On the earnings side, the issue is still more conjectural because the passage of time does not give further information on the promotions, setbacks, new jobs, or dismissals that might have taken place if the malpractice had not occurred. But there is little reason to stress these points, for they are endemic to any system that does not rely on a schedule of damages that is designed to overlook the variations in individual cases.

I have little doubt that the O’Connell and Stephenson proposal would, if adopted, effectuate serious changes in the operation of the tort system, but it is hard to know whether these changes would count as social improvements. Think of how the bidding would start out. Take any case where liability is certain under the ordinary preponderance of evidence standard of proof, and the defendant will make the offer “lickety-split.” The defendant saves pain and suffering on a case that is a dead loser. The plaintiff will in turn be forced to accept that offer unless he or she was confident that the claim could meet the higher standard of care with the exacting standard of proof. There might be some likelihood that this will be done because the defendant is not likely to resort to this approach unless the chances of liability are good under the ordinary law. Hence, for a broad range of serious cases, the pain and suffering is removed from the case. For those who think that the current system is good, and that pain and suffering is a real loss, then their result has to be wrong because it takes the strongest cases out of the system and settles them for a good deal less than the actual losses. On the other end of the spectrum, defendants in weak cases will not offer these payments because plaintiffs will in general settle for very little knowing that they have only a long shot at

trial. The social problem does not arise because the defendant lacks the proper incentive to select out those cases that merit a settlement. Rather, the social problem is that the defendant's incentive is so strong that the reduced level of compensation could compromise the level of deterrence that is supplied—assuming the current law has it right. But even if overdeterrence is an issue, why correct that by taking the *strongest* cases out of the ordinary system, when it is the weakest cases that should go? Certainly, there is little that this proposal will do to stop frivolous litigation.

These structural difficulties will feed into the political calculus. The ability to mount a strong principled objection makes it most unlikely that this proposal, or any close variation on it, will get off the ground. The political savvy of organizations such as the Association of Trial Lawyers of America makes it clear that the plaintiffs' bar occupies a veto position on tort law.³⁷ The only way that some compromise of claims will take place is if the expected value of the settlement is at least as great as it is under current law, so that only administrative expenses are squeezed out from the total amount of the payoffs. But in this case these administrative savings, even if substantial, would be matched by a decrease in the settlement value of strong claims, and politically that result will not pass. In a sense, here my own reservations feed into the hands of the trial lawyers. This proposal is dead on arrival.

IV. SAKS, STROUSE & SCHWEITZER

I next turn to the thoughtful empirical article of Professor Michael Saks, Professor Daniel Strouse, and their co-author Nicholas Schweitzer.³⁸ These three authors hope to break the inconclusive debates over the choice of the optimal legal regimes by measuring the preferences of the various parties who in modern jargon could be called the stakeholders in the system. Thus, they adopt a five-fold classification of the relevant interest groups: plaintiffs' lawyers, low-risk doctors, high-risk doctors, tort professors, and laypersons. They expect, rightly in my view, that the different positions of the various groups will lead them to have different preferences on the proper design of the legal system. Their second initial move is to group the potential solutions

37. See generally Todd J. Zywicki, *Public Choice and Tort Reform* (George Mason Univ. School of Law, Working Paper No. 00-36, 2000), <http://www.law.gmu.edu/faculty/papers/docs/00-36.pdf> (describing the ways in which interest groups such as the Association of Trial Lawyers of America influence the progress of tort reform legislation).

38. See Saks et al., *supra* note 10.

to the medical malpractice system into six types.³⁹ The first two are tort (or pretty much the status quo), and modified tort (which includes some of the standard reforms, such as caps, control on collateral damages, shorter statutes of limitation, periodic damages and the like). The third system is similar to the one advocated by Weiler, which calls for the imposition of a system of enterprise liability in which the institutional employer, but not the physician, could be held responsible. They leave open the question of whether the vicarious component of this liability is strict or negligence. Fourth, they consider the standard medical no-fault proposal that affords limited recovery for compensable injuries without the proof of negligence. Their fifth choice is the Harvard variation on the no-fault proposal, which covers provider claims that do not resolve themselves within six months, for which the patient receives a package that covers uninsured medical, limited compensation for lost income, and specified payments for various forms of hedonic loss. This package could be made available on a take-it-or-leave-it basis, and is best understood as a regime of freedom of contract once certain minimum terms are specified. The final system presented is one of binding arbitration, which stresses informal trials but otherwise tends to keep the liability rules that are found under the conventional tort system.

The authors' most novel contribution is the multiattribute utility analysis by which they evaluate what different stakeholder groups think of the various proposals. Here, they adopt a procedure that is often used to make choices in technical areas, such as the design of a rocket ship.⁴⁰ What is first done is that the designer specifies the weight that is attached to each criterion, and then the success that each of the various proposed solutions has with respect to each conclusion. In effect, a system in which there are three variables and four criterion, the examiner multiplies the weight for each test by the percentage of success it achieves, and then sums to get the best result. Thus, if we have to consider four substances—steel, titanium, plastic, and tile—over three variables—strength, heat resistance, and durability—one simple calculation might look like this for a given analyst who thinks that forty percent of the weight should be given to strength, thirty-five percent to heat resistance, and twenty-five percent to durability, and rates steel a seven on strength, six on heat resistance, and nine on durability:

$$\text{Steel} = (0.4 \times 7) + (0.35 \times 6) + (0.25 \times 9) = 7.15$$

39. *Id.* at 281–85.

40. *Id.* at 280.

Similar calculations are then made for the other alternatives and the totals are prepared. By breaking down complex decisions into measurable parties, it becomes possible for each analyst to express his own preference and then for some analysts to sum the preferences in order to reach the group choice. Obviously, a different set of parameters is needed to evaluate liability systems, and here Saks, Strouse, and Schweitzer provide us with six criterion that are drawn from the general literature: full compensation for injured parties with valid claims; essential compensation for the largest number of patients; predictable compensation for all; individual incentives to avoid adverse consequences; institutional incentives to avoid adverse consequences; facilitation of communication across groups; and corrective justice. After working through the various permutations, they concluded that communication first and then deterrence, both individual and collective, dominated any concern with correct justice. In dealing with these results, I note here this peculiar disjunction. The highest-rated system are the two no-fault alternatives, while the lowest-rated is the modified tort regime. This result hardly tracks the current state of the world, where we have only a couple of small no-fault systems that have worked indifferently, and huge numbers of modifications of the basic tort system in a profusion that defies easy summarization.

So, why the disconnect? Here, there are several explanations. First, the decisions made by individual groups are made on the strength of incomplete information about how the different kinds of systems are likely to perform in practice. They are not asked, for example, to rate the difficulties associated with their implementation, or to give explicit weight to the costs of administration associated with each. Nor do they ask the question of whether the effort to provide for proper levels of compensation will compromise the efforts to get the right level of deterrence in the system. In order to do that, the groups in question have to have a clear sense of the relevant trade-offs, which seem to be missing from their specification of the problem. In the end, therefore, it is hard as a theoretical matter to know what to make of these preferences, or indeed how durable they would be if the decisions were made after advocates for each position presented their case to the public at large.

As a political matter, therefore, this form of information is not likely to move the current situation. If, as I argued above, the definition of compensable event blocks the introduction of a sensible no-fault system, then no matter what the votes or preferences accumulated, the carriers will not buy into a system that requires their participation to be effective.

But what then could make this tractable? The contract approach. Its first consequence is that it changes the class of relevant stakeholders. Lawyers, professors, and the public all drop out. There are instead encounters by patients, physicians, and institutions. If they work out deals to their satisfaction, then they can adopt whatever mix of guaranteed and discretionary compensation that may, but need not, track the various proposals. It is therefore no longer necessary to adopt a one-size-fits-all policy across all kinds of patients, treatments, physicians, and institutions. Yet it is precisely because a market would cut out the most powerful interest group, the trial lawyers, that it will never happen. But if it could, then individual firms could do utility analysis in the form proposed by Saks, Strouse, and Schweitzer. Only now it would be called marketing research, which is what we should have been doing all along.

V. SLOAN, MATHEWS, CONOVER & SAGE

The last of these four articles, by Professors Frank Sloan, Christopher Conover, William Sage, and their co-author Carrie Mathews, takes a different tack and looks at a fraction of the medical malpractice insurance market that has been largely ignored in the ongoing concern with the availability crunch for insurers.⁴¹ State-run Patient Compensation Funds (PCFs) are now in place in nine states. In general, these funds are designed to provide excess levels of coverage to physicians who find it difficult to obtain insurance in the voluntary private market. Three of these funds are mandatory and six are voluntary. In both situations, the PCFs acquire their funds from their customers and not from any form of state subsidy, which is preferable. In some instances, they rely on experience rating, and in others they do not. In some cases, they have the authority to remove covered physicians from the rolls and in others they do not. The small number of states in the sample and the wide variation in plans make it difficult to form any potent generalization about the operation of the system, but it seems fair to say that the consensus view is that these organizations have made some modest positive contribution to the states in which they are organized, even though only one PCF, that for South Carolina, appears to play a dominant role.⁴²

There is little that I have to say to question this careful and balanced study, so I will just relate the question of the role of PCFs to the larger question of the misshapen nature of basic liability. Here, the

41. See Sloan et al., *supra* note 10.

42. *Id.* at 261.

simplest question is to ask whether these organizations would be needed at all if the basic scheme of liability for malpractice was contractual. The first predictive question is whether either physicians or institutions would continue to bear any residual risk for medical mishaps. My own sense is that competitive pressures would continue to have a reduced system of liability, for which it could be sensible to require some insurance beyond the norm, if only for the excess layers now occupied by the PCFs. But here the expected exposures would be far less, and there is no reason to think that private markets could not provide that coverage at premiums far lower than those which are now required. Cure the basic system, and there is little reason to think that the derivative insurance markets will offer any serious complications.

VI. CONCLUSION

I am now in a position to offer a brief cautionary word for medical malpractice, secure in the knowledge that it will not be tried: privatize and survive, or continue to blunder about in the current system with legislative patch on legislative patch, for a system that should be traded in and not reformed. Ptolemy tried epicycles to bring the universe into order. It won't work for medical malpractice, either. We need Copernicus, and fast.